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Report Series 1990

90-7 Long-Term Care Reform

AMO's Response to
Strategies for Change: Comprehensive Reform of Ontario's Long-Term Care Services

Association of Municipalities of Ontario
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MISSION STATEMENT

AMO unites Ontario's municipalities.

We take pride in promoting, supporting and enhancing strong and effective municipal government.

We provide strategic leadership by:

- developing and effectively promoting responsive quality policy;
- informing and educating governments, the media and the public;
- marketing innovative and beneficial services.

Our elected representatives, municipal officials and association staff form a team which values and respects:

- diversity and local autonomy;
- fairness and equity;
- consultation;
- consensus;
- co-operation.

TABLE OF CONTENTS

EXECUTIVE SUMMARY 1

1 INTRODUCTION 1
- 1.1 Province's Reasons for Reform 2
- 1.2 Devolution of Health and Social Services 3
- 1.3 AMO's Position on Long-Term Care Reform 4
- 1.4 AMO's General Concerns with *Strategies for Change* 5

2 THE ROLE OF MUNICIPALITIES 6

3 PLANNING AND MANAGEMENT: THE PMSSR CONNECTION 7

4 FUNDING 10
- 4.1 The Current Funding Role of Municipalities 10
- 4.2 The Cost of the Reformed Long-Term Care System 11
- 4.3 The Future Funding Role of Municipalities 13
- 4.4 User-pay Fees 14
- 4.5 Long-Term Care Facilities 17

5 SERVICE ACCESS ORGANIZATION AND FACILITY PLACEMENT COMMITTEE 19
- 5.1 The Service Access Organization 19
- 5.2 Facility Placement Committees 21

6 PROGRAM 22
- 6.1 AMO's General Concerns 22
- 6.2 In-Home Services 24
- 6.3 Community Support Services 25
- 6.4 Funding of In-Home and Community Support Services 26
- 6.5 Informal Caregivers' Support 27
- 6.6 Long-Term Care Facilities 29
- 6.7 Specialized Services 31
- 6.8 Human Resources 32
- 6.9 Areas *Strategies for Change* Does Not Address 34

7 CONCLUSION 35

8 SUMMARY OF RECOMMENDATIONS 36

9 APPENDIX A 38
- 9.1 Definitions 38

10 ENDNOTES 41

11 BIBLIOGRAPHY 42

12 MUNICIPAL ACKNOWLEDGMENTS 45

13 COMMITTEE ACKNOWLEDGMENTS 46

EXECUTIVE SUMMARY

This report represents the Association of Municipalities of Ontario's response to the previous provincial government's policy paper, *Strategies for Change: Comprehensive Reform of Ontario's Long-Term Care Services*. The policy paper represents the beginning of a comprehensive reform of Ontario's long-term care and support programs which proposes the consolidation of health and social services for the elderly and physically disabled adults.

AMO's comments on *Strategies for Change* are submitted in the context of the current provincial-municipal relationship, including the existing legislative requirements for mandatory municipal involvement in certain services. This response to *Strategies for Change* does not address the possible reassignment and/or realignment of roles and responsibilities in the context of the wider provinicial-municipal relationship. As is discussed later in this response, AMO recommends that such considerations should be made in the context of AMO's response to the Provincial-Municipal Social Services Review.

Strategies for Change involves two main components: the reform of long-term care services and programs and the establishment of an integrated health and social services management structure for which responsibility could be transferred to a local level of authority in the future. This concept of service integration echoes the principles of the Premier's Council on Health Strategy which proposes an overall comprehensive, integrated and coordinated system of health and social services with eventual devolution of authority and responsibility to the local level.

Long-Term Care Services

With regards to long-term care services, AMO recognizes that reform of the system is needed, that the integration of health and social services for the elderly and disabled is a necessary step, and it applauds the provincial government for beginning to address this area.

But despite being legislative and historical partners with the provincial government, and despite the intention to devolve responsibility to the local level in the future, municipalities were not consulted or involved in the development of the reforms proposed in *Strategies for Change*.

Municipalities have much to offer towards assisting in the success of long-term care reform. In addition to their

involvement in funding, delivering, and planning for services, local governments have great knowledge of local needs and requirements and expertise in the human service needs of their communities. They can contribute towards making long-term care reform a success.

In this response, the Association of Municipalities of Ontario proposes several considerations which it recommends should be considered in the formulation of the long-term services system. For example, AMO questions the exclusion of rest and retirement homes from the continuum of long-term care services, and suggests that the needs of the physically handicapped are not adequately addressed. The Association also poses several questions and suggests that further information and consultation are required to resolve outstanding issues.

The main concern of the municipal sector is that the policies for long-term care reform were determined prior to any consultation with the municipal sector. AMO has requested that the Minister of Community and Social Services, the Honourable Zanana Akande, withdraw *Strategies for Change* as a policy paper and re-issue it as a discussion paper. This will enable input and effective consultation with all the key players in the long-term care system. AMO's response is seen as a first step towards this further discussion and consultation with the provincial government.

Management Responsibility

As government partners, the municipal sector should also be involved in developing the necessary management, planning and funding structure for reform of the long-term care system. In fact, a successful precedent for this already exists. Starting in 1987, municipalities have worked as partners with the province on the PMSSR Committee towards establishing a provincial-municipal management structure for the social services system. While that review did not specifically address health services, it did recognize that greater integration and coordination of health and social services were important objectives.

AMO therefore suggests that the proposal to transfer responsibility for the management of the system to a local authority be examined in consultation with the municipal sector and in the context of the principles and framework proposed in the *Report of the PMSSR*.

In sum, municipalities want to be partners with the provincial government in meeting the important objectives of long-term care reform. They have much to offer in

experience and knowledge towards improving the services to the elderly and physically disabled living in their communities and should be consulted as a key government partner in this reform. The Association of Municipalities of Ontario presents this response to the new provincial government as a first step towards beginning dialogue and consultation on this most important issue.

1 INTRODUCTION

The previous provincial government's policy paper, *Strategies for Change: Comprehensive Reform of Ontario's Long-Term Care Services* was released on May 30, 1990. It represents the beginning of a comprehensive reform of Ontario's long-term care and support programs. Through it, health and social services for the elderly and physically disabled adults will be consolidated and a new integrated system will be introduced to deal with the growth expected in the demand for and cost of these services.

The policy was spear-headed by the Ministry of Health, Office for Senior Citizens Affairs, Office for Disabled Persons, and the Ministry of Community and Social Services, with assistance from the Cabinet Office and Management Board of Cabinet. The reform aimed to build a coherent, integrated service system on the foundation of existing in-home, community support, and long-term care facility services.

The policy emphasizes informal caregiver, in-home and community support services in an effort to help people live as long as possible in their homes and communities rather than having them move into more limited and costly facility care. It also attempts to streamline access to the entire system by offering a single point of entry, the service access organization. *Strategies for Change* also offers direction for building the basis for the much larger system soon needed to service this area.

It was expected to take years to fully implement the reform. However, several components of the reform have already been instituted such as the integration of long-term care and support programs from the Ministry of Health and Ministry of Community and Social Services into a new Division of Community Health and Support Services and the hiring of fourteen area managers.

AMO's comments on *Strategies for Change* are submitted in the context of the current provincial-municipal relationship, including the existing legislative requirements for mandatory municipal involvement in certain services. This response to Strategies for Change does not address the possible reassignment and/or realignment of roles and responsibilities in the context of the wider provinicial-municipal relationship. As is discussed later in this response, AMO recommends that such considerations should be made in the context of AMO's response to the Provincial-Municipal Social Services Review.

1.1 Province's Reasons for Reform

Several factors and trends have made reform of Ontario's long-term care services necessary: new expectations, social and demographic change, and growth in service demand and cost. Examples of social and demographic change include the following:[1]

- average life expectancy for women is now 80.5 years and for men is 73.7; Ontarians now expect to live almost one-third of their lives in retirement;
- by the year 2000, the number of individuals over 65 years of age will increase by about 400,000;
- by 2011, the year in which the first wave of baby-boomers will become senior citizens, the over-75 age group will have doubled from its 1988 level;
- by the year 2020, people over 65 years of age will account for almost 20 per cent of Ontario's population. That means its per centage of the population will double in the next 30 years;
- the number of those people aged over 85 is projected to increase at the fastest rate, about 4 per cent per year. This is the group of individuals which tended to use more health care and social services;
- based on prevalence rates generated from the Statistics Canada Canadian Health and Disability Survey in 1983/84, current estimates indicate that more than 983,000 Ontario adults, aged 15 years and over, have physical disabilities resulting in some degree of functional loss; and,
- the likelihood of disability increases dramatically with age, and about 60 per cent of Ontario's adult disabled population is 55 years of age or older.

There are also several other reasons which lead to this proposed reform. As represented in a series of provincial reports, individuals want to stay in their homes and communities as long as possible. This was noted in the provincial Senior Citizen's Affairs' *A New Agenda*, The Ministry of Community and Social Services' *Challenges and Opportunities*, and the Ministry of Health's *Deciding The Future of Our Health Care*. It was also noted in three health care reports the provincial government received in 1987

from the Ontario Health Review Panel, chaired by Dr. John Evans; the Panel on Health Goals, chaired by Dr. Robert Spasoff; and, the Minister's Advisory Group on Health Promotion, chaired by Steve Podborski. The National Advisory Council on Aging had also adopted this position, which was cited in *The NACA Position: On Community Services in Health Care for Seniors*.

Strategies for Change also indicates that long-term care costs are expected to climb as more of the population ages and the physically disabled population increases because of the progress of medical intervention. The provincial government already spends about $2 billion on long-term care services, and, as noted in the report, there are currently inefficiencies in the system. For example, approximately 10 to 15 per cent of all acute care beds are used by people requiring long-term care.[2] That means expensive, high-care beds are being used for people who could more appropriately be accommodated in other lesser-care facilities. This inappropriate use of acute care beds also means those who really need these high-care facilities are being denied that service.

Thus, to best use the existing system, limit expenses and meet growing demand, *Strategies for Change* was introduced as a first step towards integration and enhancement of the existing system. The goal was thus to provide people with services to allow them to remain in their homes as long as possible and to also allow only those needing more extensive and expensive care to be admitted to the more expensive facilities.

1.2 Devolution of Health and Social Services

Strategies for Change states that the "provincial government is interested in moving toward a greater local management of human services. It recognizes, however, that policy and program reform of long-term care is necessary before responsibility can be transferred to the local level authority."[3] Such a transfer of authority is usually referred to as "devolution".

Strategies for Change is not explicit in defining what body could or should be the local level of authority. However, the Premier's Council on Health Strategy discusses how devolution of health and social services could occur to different locally-based entities, such as provincial commissions, special purpose bodies and local governments.[4]

The Premier's Council also states that the general direction of the province to divest services to the local level will likely continue given the general direction of the province to reduce its direct service role.

It is therefore clear that both the intent of *Strategies for Change* and the work of the Premiers Council on Health Strategy is for devolution of authority and responsibility for health and social services to the local level. These responsibilities include comprehensive planning, management and the allocation of funds.

1.3 AMO's Position on Long-Term Care Reform

As outlined above, *Strategies for Change* involves two main components: the reform of long-term care services and programs and the establishment of an integrated health and social services management structure for which responsibility could be transferred to a local level of authority in the future.

Reform of Long-Term Care Services

AMO recognizes that reform of the long-term care system is needed, and it applauds the provincial government for beginning to address this area. In fact, AMO sees several positive components to the reform. These include: the flexibility of care; the appeal process; the placement committees which will ensure that applications are reviewed so the most needy people are placed in facilities; the funding of facilities for the level of care they provide; and, the rationalization of funding.

But, municipalities were not consulted during the process of shaping the strategies for reforming long-term care services and programs. Municipalities have a considerable history of involvement in health and social service programs. They have developed and integrated into programs such as community Health Care, acute and chronic home care, and Integrated Homemakers Program. But, despite being legislative and historical partners with the provincial government, and despite the intention to devolve responsibility to the local level in the future, municipalities were not included in the government's planning for this change.

Municipalities have much to offer towards assisting in the success of long-term care reform. In addition to their involvement in funding, delivering, and planning for services,

local governments have great knowledge of local needs and requirements and expertise in the human service needs of their communities. They can contribute towards making long-term care reform a success.

Management Structure

Municipalities, in conjunction with the provincial government, are involved in the funding, delivery, and planning of several long-term care health and social services. As government partners, the municipal sector should also be involved in developing the necessary management structure for reform of the long-term care system which would include planning and the allocation of funds. In fact, a successful precedent for this already exists. Starting in 1987, municipalities have worked as partners with the province on the PMSSR Committee towards establishing a provincial-municipal management structure for the social services system. While that review did not specifically address health services, it did recognize that greater integration and coordination of health and social services were important objectives.

AMO therefore suggests that the proposal to transfer responsibility for the management of the system to a local authority be examined in consultation with the municipal sector and in the context of the principles and framework proposed in the *Report of the PMSSR*.

In sum, municipalities are partners with the provincial government and they should be consulted as a key government level involved in this reform.

1.4 AMO's General Concerns with *Strategies for Change*

Municipalities are concerned about many elements of the proposed reform such as planning, management, funding and program issues. But the main concern raised which is emphasized in this response to *Strategies for Change* is the process which was used in developing the proposed reform of the long-term care system.

Implementation of the Reforms

As noted previously, while *Strategies for Change* was still being discussed by municipalities throughout Ontario, the government was already implementing the program. It created a new provincial government division to oversee the reform and it began hiring fourteen service managers to begin to implement the program.

At its August 19, 1990 meeting, AMO's Board of Directors asked the provincial government to stop its implementation of long-term care reform until the relationship between the reform and the Provincial-Municipal Social Services Review (PMSSR), which defined municipalities and the province's role in social services, could be worked out. In particular, AMO's board requested that:

> "the provincial government withdraw the *Strategies for Change* document and re-issue it as a discussion paper and that implementation plans for the reforms be immediately suspended. Furthermore, subsequent discussion should take place within the broader context of the PMSSR consultation process."

The Honourable Charles Beer, who was then Minister of Community and Social Services, noted during his August 22 speech to the AMO Annual Conference, that he was willing to meet with AMO representatives and discuss that and related concerns. AMO welcomed that opportunity and confirmed in an August 31, 1990 letter to the Minister that it was considering the most effective way to organize that discussion.

Since that time, AMO has reiterated to the new Minister of Community and Social Services its request that *Strategies for Change* should be withdrawn and considered as a discussion paper. As suggested, AMO hopes that the new provincial government will do that and establish with the municipal sector a process for more comprehensive discussions about the direction for the program and its management structure.

2 THE ROLE OF MUNICIPALITIES

Simply stated, the central dilemma faced by the municipal sector in addressing a document such as *Strategies for Change*, which proposes a substantial shift in the way an area of our social service system is run, is whether municipalities want to be in or out as major players.

Of course, Ontario's long-term care system is too complex a network to allow for such over-simplifications. Planning, funding, management and delivery mechanisms for long-term care programs vary from municipality to municipality, and are often the result of the historic, economic and geographic character of a particular region.

However, the same pressures for reform that have resulted in *Strategies for Change* are forcing municipalities to take a long, hard look at their role within the system. As already mentioned, the Provincial-Municipal Social Services Review (PMSSR) is a good example of this sort of examination of roles and responsibilities.

While the PMSSR analyses the entire social services system, the introduction of the long-term care reforms demand that the municipal sector decides upon its own desired level of involvement in the proposed integrated health and social services system for seniors and the physically disabled. From consultation and discussion with our membership, it is clear to the Association that municipalities do want to remain involved. Municipalities have a profound sense of responsibility for long-term care; historically they have been involved in the funding and delivery of various long-term care programs in both the health and social services fields.

However, municipalities have been excluded from participation in two main elements of long-term care reform. The central "invention" of the long-term care reform strategy, the Service Access Organization (SAO), is modeled closely upon the municipal Home Care programs; however, the municipal sector has even been specifically excluded from opportunities to sponsor the SAO. Secondly, the expansion of the role of local District Health Councils (DHC's) has given more responsibility for planning long-term care services to a special purpose body, and stands in contradiction to the recommendations of the *Report of the PMSSR* for an enhanced planning role for municipalities.

AMO suggests that if the approach to long-term care reform is to involve a partnership between the provincial government and municipal sector then municipalities must be consulted. The Association believes that without such consultation and consideration, the municipal sector cannot make important decisions about its role within a reformed long-term are system and without active municipal participation, effective long-term care reform cannot take place.

3 PLANNING AND MANAGEMENT: THE PMSSR CONNECTION

Strategies for Change bills itself as a *comprehensive* reform of Ontario's long-term care system. While there is no question that the current situation requires a major over-

haul, the Association of Municipalities of Ontario questions whether a *program* review such as *Strategies for Change* can bring about comprehensive reform. AMO suggests that to achieve the goals laid out in the document, the crucial underpinnings of the system, which are the roles and responsibilities for planning and management, must be examined and reformed as well.

The Association believes that the long-term care reforms do not go far enough in that direction. This is particularly disturbing to AMO in light of its extensive efforts in this area over the last few years, namely, the Provincial Municipal Social Services Review (PMSSR). It must be stated as well, that the Ministry of Community and Social Services (MCSS) worked equally hard on this process, and the Association is disappointed that the results of the deliberations on planning and management responsibilities are not in evidence within *Strategies for Change*. Planning and management issues are the key areas where the two initiatives, long-term care reform and the PMSSR, should intersect. It is only upon a rational, mutually acceptable delegation of responsibilities that program reform can be based.

Planning

Current mechanisms for planning for services are disparate and inconsistent across the province. While the Ministry of Community and Social Services has primary responsibility for planning, a great deal of activity is carried out at the local level. However, it is often fragmented and piecemeal. In a given municipality one can find any number of organizations planning for their respective client groups. With regard to long-term care "clients", the complexity of the situation is increased because of the overlap of social and health type services.

While *Strategies for Change* ostensibly addresses the planning issue, particularly in Strategy #10, "Ensuring Community Involvement", it does not come anywhere near recommending an overall plan. The basic premise seems to be that the planning process should be locally-driven, with the active participation of both consumers and service providers. However, the "service providers" are referred to rather vaguely and as a generic group whose opportunities for input will vary according to the planning mechanisms used in particular communities, e.g. Social Planning Councils or District Health Councils. Notably, it is specifically their roles that the PMSSR attempted to come to terms with and made recommendations about.

AMO believes strongly that the *Report of the PMSSR's* recommendations for social services planning should be integrated into the long-term care reform strategy. That is, municipal government should be delegated primary responsibility and serve as the *focus* for planning and preparing a community social services plan:

> "Municipal governments are involved in planning the growth, development, and quality of life in their communities. A number of municipal governments are already taking the lead in developing social development plans. In addition, placing this responsibility in municipal hands puts the planning process close to the community, where its effects will be felt. Other reasons to support a municipally led process are experience and accessibility."[5]

The PMSSR Committee also considered that the planning process for social services should be coordinated with planning for community health services. In recommending this, the Committee also questioned the proposed enhanced planning role for District Health Councils proposed by the Ministry of Health:

> "The Committee is concerned that this means of achieving integration of health and social service planning focuses on DHCs, MCSS staff, and the Ministry of Health, and appears to exclude municipal governments. Municipalities, with their broad community perspective, should play a key role in planning for community health and social services, and we have so recommended in this report."

Therefore, in accordance with the recommendation of the *Report of the PMSSR*, AMO recommends that municipal government should serve as the focus for planning and the preparation of a comprehensive community social services plan for their communities.

Management

Current management responsibilities within the social services system differ depending on the service category. For example, for long-term care services for the elderly, the municipal and voluntary sectors have primary responsibilities as service operators. The voluntary sector is also heavily involved in providing services for persons with disabilities, though the province has the largest management responsibility there. Finally, the volunteer sector has the

largest role in managing community support services, while the province and municipalities are more involved as funders.

Upon analysis, *Strategies for Change* does not appear to address the question of service management in a very direct or new way. In fact, the document seems to assume the status quo by either ignoring the issue or by implication. The Association notes in particular that when discussing the need to integrate in-home services (Strategy #2), the fact that the programs targeted for integration are generally administered by different organizations, is not addressed. The same can be said for the reform plans for community support services, specialized services and long-term care facilities. The most appropriate roles for the key players in the system was not adequately addressed.

As with planning, the *Report of the PMSSR* also proposes a rational management system which would integrate services in a way that would facilitate their administration. As with planning, AMO believes that the long-term care reforms must be synchronized with the PMSSR process in order to ensure positive change within the long-term care system. The Association therefore strongly endorses Recommendation 20 of the PMSSR Report, which states:

> "Any proposed change in the long-term care system that would substantially affect the municipal service management of community-based support services should be subject to further discussions between the Ministry of Community and Social Services and the municipal sector."

4 FUNDING

4.1 The Current Funding Role of Municipalities

Municipalities currently are partners with the province in providing funding for the long-term care system. Municipalities already play a significant role in funding social programs, some of which is mandated by legislation and some of which is discretionary. At present, municipalities fund the following:

Long-term care facilities (mandatory cost-sharing)	Municipal Homes for the Aged:	50 per cent of capital costs, and 30 per cent of the deficit for operating

		costs. In 1988-89 this amounted to approx. $95 million dollars.
Community support programs and in-home services (discretionary cost-sharing)	Elderly Persons' Centres:	A minimum of 20 per cent of both operating and capital costs.
	Homemaker Services:	20 per cent of costs.
	Nurses Services:	20 per cent of costs.
	Home Support Services:	variable amounts.

Municipalities also pay administrative costs which are not recognized for cost-sharing by the province. These costs include support services, computer programs, automated services, and legal and human resources. There are also some program costs which municipalities also provide for operating programs which are not factored into the province's cost-sharing formula.

Municipalities also fund an assorted range of health services for the elderly and physically disabled adults, but these play a much lesser funding role than social services.

4.2 The Cost of the Reformed Long-Term Care System

It is difficult to know how much the new long-term care system will cost. *Strategies for Change* notes that provincial costs in this area now are about $2 billion, and they are expected to increase with the size of the elderly and physically disabled population.

Costs in the related ministries are already increasing. *Deciding The Future Of Our Health Care*, a discussion document released by Ontario's Ministry of Health in April 1989, said:

> "In the last ten years, the cost of health care has risen by 63.4 per cent, while the provincial economy has grown by only 42.7 per cent. In 1988, we spent almost $13 billion on health care - one third of the entire provincial budget."[6]

Ontario's Ministry of Community and Social Services (MCSS) has also seen major cost increases. In 1986-87, MCSS accounted for $3.3 billion or 10.1 per cent of the

province's expenditures and, in 1987-88, it accounted for $3.7 billion or 10.6 per cent of provincial expenditures. Elderly services were also the second largest part of MCSS's budget, accounting for 23.8 per cent of the ministry's spending. The cost of elderly services was expected to soon increase to 24 per cent of the budget.[7]

Municipal costs have also been increasing. In 1986, municipalities contributed 24 per cent of social service expenditures with the province and federal governments contributing the rest. AMO notes in *New Dimensions* that municipal expenditures for social services, as a per centage of total municipal operating expenditures, increased from 13.48 per cent in 1977 to 17 per cent in 1986.[8]

Strategies for Change does not indicate what the overall cost of this reform could be. In announcing some long-term care funding in the Ontario legislature on April 25, 1990, then Minister of Community and Social Services, the Honourable Charles Beer, noted that over the next six years, the province would invest $2 billion in new money in the long-term care system. By the fiscal year 1996-97, he said new funding would rise to $640 million annually. Of those new dollars, $460 million annually would come from the province. Another $180 million was to be recovered through user-fees from consumers.

There are, however, many signals in *Strategies for Change* that costs in this area could increase in many ways. To support the new system, the availability of in-home and community services will have to be increased. The cost implications of this are unclear.

During the past few years the provincial government also began to increase the wages of homemakers who work in many of these programs. In the past few years, homemakers' wages have increased from $4.50 to $8.30 per hour. In his April 25, 1990 statement to the Ontario legislature, then MCSS Minister, Charles Beer, announced that the province would dedicate $52 million to the long-term care reform in the current fiscal year. Of that, $10.9 million was to be used to improve wages and benefits paid to homemakers.

AMO is in favour of better pay for homemaking staff. But given that *Strategies for Change* acknowledges that such staff are key to the reformed system and they need to be better trained and educated, municipalities are wondering what the implications of these cost changes are for the municipal sector.

Municipalities are, in general, concerned about what the total cost of this new system could be. It is inferred in *Strategies for Change* that municipalities are expected to continue to be financial partners in a system for which they have insufficient financial information. AMO therefore requests that the provincial government conduct a study to ascertain the projected costs of this new system. Informed decisions can only be made when such information is available.

RECOMMENDATION # 1 :

The province should undertake a study to determine the projected costs of long-term care reform and provide the information and research data which served as a basis for its long-term care policy recommendations.

4.3 The Future Funding Role of Municipalities

Strategies for Change infers that municipalities will continue to fund this system to the same level they now are funding it. The only other reference which *Strategies for Change* makes to the role which municipal funding will play in this reform is in the funding of long-term care facilities. *Strategies for Change* notes the following:

> "The funding of long-term care facilities currently includes important contributions by municipalities and charitable organizations. The funding model described above does not exclude such contributions or other contributions to proprietary facilities."[9]

The future funding role of municipalities in the long-term care system is not clearly stated. Of major concern is that *Strategies for Change* was released at the same time as the *Report of the Provincial-Municipal Social Services Review*. The report is an advisory document which presents a provincial-municipal management-funding framework for social services. Municipalities, however, were still responding to this document when *Strategies for Change* was released.

The provincial-municipal roles and responsibilities for the management and funding for social services still is being

discussed. Now, with *Strategies for Change*, health services have been added to this equation. These points, coupled with the fact that long-term care costs are expected to increase significantly, require that provincial-municipal management and funding responsibility for long-term care services need to be clarified.

As recommended with regards to planning and management responsibility, the Association of Municipalities of Ontario proposes that funding be resolved in the context of the PMSSR process.

RECOMMENDATION # 2 :

The province and the Association of Municipalities of Ontario, through the PMSSR consultation process, should resolve the funding arrangements for the long-term care system.

4.4 User-pay Fees

The current long-term care service system has a variety of user-pay charges to consumers. These charges have evolved over the years with different policies and legislation, and thus many of the service or program policies are inconsistent.

There are presently differences in co-payments between residential care and extended care. Fees for community and in-home support services are also inconsistent, depending on provincial and agency-determined charging policies. The same service may be offered at different charges or no charge. Many specialized services also charge user-pay fees, with the province funding 100 per cent of the remaining cost.

In *Strategies for Change*, the government proposed a new "consumer charging policy" - user-pay charges - which would continue the present system of having consumers of services pay all, part, or none of the service cost, depending on their ability to pay.

This strategy, spelled out in Strategy 8, noted that user-pay fees would help to share the rising costs in this area among government levels and the people who use the system.

The proposed user-pay policy is aimed at achieving consistency in fees charged by both facilities and community-based services. It plans to eliminate different user-pay fees between residential and extended care facilities, and it plans to institute this program in facilities when the new funding and budgeting systems start.

Strategies for Change states that the fees would "more accurately" reflect accommodation costs such as maintaining and administering a facility or personal residence, food, laundry, and housekeeping in facilities. There would be no fees for nursing or personal care services or facility programs. The difference in fee plans between facilities and community-based services would be that:

- in facilities, people's ability to pay would be based on income and assets: and,.

- in community-based services, people's ability to pay would be based solely on income, and not on assets.

Under this new system, people would be charged for community support services according to their ability to pay. They could pay all of a service's cost if their net income was over $50,000, part of a service's cost if their net income was $20,000-50,000, or nothing if their income was under $20,000 and they cannot afford to pay. Since the government was planning to streamline the "consumer charging policy" towards a consistent charging policy for facilities and community support services, the province should also clarify whether these income levels are to apply to individuals in facilities as well as individuals receiving community support services.

So far, there has not been much information on the user-pay system's costs. Earlier in 1990, the government announced that by 1996-97, there would be $640 million in new funding for the system. Of this, $460 million would come directly from the province and $180 million would be recovered through consumer user-fees.

With regards to this new user-fee policy, AMO would like clarification on the following:

- Is the user-pay fee revenue-neutral, or is it designed to raise more money than now is raised? It would appear from statements that the new system will raise new money.

- Will the province be able to get all the user-fee revenue it anticipates from the $20,000 to $50,000 income group? Many users of the long-term care system have income of less than $20,000.

- Will the net income range for determining ability to pay be fully indexed?

- What will the needs test be for this policy?

- What will be the impact of this new policy on health costs?

- Should assets be used consistently across the continuum of care as a basis for determining user pay-fees?

- If those who now get free health care in home care programs - such as in free homemaking services - have to pay for these services, what impact might this have on chronic and acute care hospitals? For example, families may be reluctant to discharge members from chronic and acute care hospitals if user-pay fees are required for in-home services.

AMO supports the introduction of user-pay fees in a more rigorous way to help support the costs of the system. But, the Association notes that if municipalities are involved in cost-sharing long-term care services, then these user-pay fees should go towards offsetting municipal as well as provincial costs. AMO also recommends that further work and consultation on the mechanics of user-pay fees is necessary.

RECOMMENDATION #3 :

The Association of Municipalities of Ontario should be consulted on the details of the user pay system. If municipalities are involved in cost-sharing long-term care services, then revenue from user-pay fees introduced in the long-term care system should help to offset municipal as well as provincial costs for this system.

4.5 Long-Term Care Facilities

The current funding model for Homes for the Aged has a formula for sharing operating deficits between the province and municipality or charitable organization responsible for that facility. Seniors in residential care pay for the cost of their care. If they cannot afford the full cost, the province pays 70 per cent and the municipality pays 30 per cent of the residential care deficit. For residential care residents from unorganized territories, the Ministry provides 100 per cent of the deficit.[10]

In extended care, the provincial policy was to pay a per diem rate with a set ceiling. Residents would pay a per diem user fee for their room and board. The province then was to pay 70 per cent and the municipality or charitable home would pay 30 per cent of the costs up to a maximum. The municipality was to be responsible for 100 per cent of all costs beyond that. The federal government provides financing as block funding through Established Program Financing, which is unlike the Canada Assistance Plan in that it is not legislated.

Funding for each program currently is negotiated separately with the responsible ministry, so there is no overall view of community needs. Current funding now is based on bed designation rather than residents' needs.

Strategies for Change proposes that in the context of long-term care reform, it is expected that long-term care facilities will increasingly serve people who need more heavy and complex care. To meet this change, Strategy 7 introduces a new strategy for the coordination of funding policies which would apply to nursing homes, homes for the aged, and chronic care. This strategy included:

a) A new funding policy for homes for the aged and nursing homes. The three kinds of funding for these would be:

   1) Nursing and personal care: the institution would be paid according to the kind of care it gives a patient. There would be ceilings on what the province pays.

   2) Program: the facility would get a consistent per diem, but the province could review its funding levels in this area if it decided to fund specialized programs in the facilities. There would also be a ceiling for what the province paid in this area.

3) Accommodation: there would be a fixed per diem funding for such costs as housekeeping, laundry, building maintenance and administration. Facilities could generate a surplus in this area, provided they maintained provincial standards of service and operation. The exception would be "raw food" costs, which would be funded up to a predetermined limit.

b) The introduction of a classification system to classify residents' care requirements for funding purposes. This would not apply to admission or care purposes. This would be modelled on the Alberta Patient Classification System; a provincial advisory group has been dealing with this topic.

Strategies for Change states that it is expected that municipal and charitable funding contributions will continue. It also states that the province will not fund a municipal or charitable facility's operating deficit. Because that is a change from the current system, there would be an adjustment period for several facilities. It is also noted that other policy changes would be needed to allow facilities to serve individuals who require greater amounts or different types of care.

With the introduction of this new system, there are several areas which require clarification:

- What will be the financial impact of this new system on municipalities? There is particular concern about the impact on municipalities of the province's new capping formulas for facilities. Municipalities have been moving increasingly into funding 100 per cent of cost over runs as a result of provincial capping.

- If the same funding formula is to be applied to nursing homes and homes for the aged, then will the taxpayer be subsidizing for-profit facilities?

- Will this new system allow facilities to have certain beds designed and funded for respite and periodic care?

5 SERVICE ACCESS ORGANIZATION AND FACILITY PLACEMENT COMMITTEE

5.1 The Service Access Organization

Strategies for Change proposes the institution of a service access organization (SAO) which would provide a clearly identifiable point of access to long-term care services. The purpose of the SAO would be to have a one-stop service for access, referral, assessment and service coordination for that area's long-term care health and social services.

The service access organization is modelled after the home-care system and Integrated Homemaker Program which already operate in many areas of Ontario.

Strategies for Change states that the SAO would be an authorized agency in 38 or more Ontario areas. Its aim would be to simplify people's access to services and allow for full use of community resources. The SAO would manage resources for assessment and co-ordination of service, and purchase in-home services as required by an individual's service plan. The SAO would also require a budget for administration and service co-ordination, operating a facility placement committee, and buying formal in-home services. The SAO would also:

- provide referrals to other community services and resources for those who wish to access those themselves;
- try to keep people at home as long as possible and only when that is no longer a viable option, put them in a facility;
- screen those needing in-home services or facility care;
- target finances only to those who most need help; and,
- co-ordinate waiting lists and set priorities for needs.

The agency would be a single organization which would act as a co-ordinating mechanism. It could be a new or existing community organization, but *Strategies for Change* states that direct service providers would not be able to sponsor the SAO in order to prevent the perception of conflict of interest by consumers. Many municipalities are direct service providers, so if the province continued this

condition, it would exclude municipalities from sponsoring the SAO.

AMO understands this may be a necessary barrier for some agencies, but the province must distinguish between a local agency and local government. Municipalities are not agencies; they are another government level and should not be barred from sponsoring this service.

Thus, municipalities should be offered the first opportunity to sponsor an SAO in their communities. If they chose not to accept that opportunity, they then should be partners in determining how the SAO is established in their communities.

RECOMMENDATION #4 :

If municipalities continue to have significant responsibility in this area, then municipalities should be offered the first opportunity to sponsor a service access organization in their communities. If they chose not to accept that opportunity, they then should be partners in determining how the SAO is to be established in their communities.

While that is the key municipal concern about the SAO, AMO has also identified several other issues related to the service access organization. A major one is that *Strategies for Change* notes there will be SAOs in 38 areas of Ontario. These do not correspond to municipal boundaries, and AMO suggests that these should be aligned to follow upper tier and/or municipal boundaries.

Strategies for Change proposes that the SAO will control access to long-term care facilities but not community support services. People could thus be rejected from a facility based on the fact the community service could provide for them. Then, the community service could refuse to serve that person. AMO suggests that the province should define what authority the SAO has to say that community service is available to a person.

Other points of clarification are requested for the following:

- how the SAO budget will be determined, and whether its funding structure will be established to reflect the fact that different communities have different needs;

- who decides the SAO's budget;
- how much flexibility the SAO's funding envelope will contain, and whether its funding will be related to care needs;
- how the new organization will structurally integrate health and social services; and,
- on-going developments in this area, such as when the long-term care service management offices will begin to fully function.

5.2 Facility Placement Committees

Strategies for Change notes that the service access organization would have a facility placement committee which would be the only body which could allow people admission into long-term care facilities. This system would be modeled on the Placement Coordination Services now operating in some parts of Ontario. The committee would review all applications for placement in long-term care facilities. It would also ensure all community and in-home service options are checked before someone was admitted to a facility. The committee would be an inter-disciplinary group, which would include a geriatrician or other physician, a community nurse, social worker, occupational therapist or physio-therapist, and a consumer representative.

Strategies for Change is unclear in stating whether those individuals serving on the facility placement committees will be staff or volunteers. AMO believes they should be staff because there could be severe problems getting sufficient volunteers who could spend the great amount of time needed to process all of these assessments. If the committee is staffed by volunteers, it may also not be practical to assess every patient entering the system as is proposed in *Strategies for Change*.

An important consideration which requires further discussion is the possibility that this system could erode consumer choice. On the one hand, *Strategies for Change* states this system should recognize and respect people's dignity and individuality and that it should be operated to maximize consumers' independence and choice. On the other hand, it also notes that the facility placement committee will prioritize needs and resource availability to direct that person's choice.

Consumers may lose their freedom of choice, particularly if they want to live in a facility to avoid being lonely, but are not allowed to do that because their needs are assessed as not being sufficient to warrant that type of care. For example, will people be able to shop around for the facility of their choice if there are beds available in several places? These issues should be addressed before implementation of this system in order to ensure that this system responds to individual consumer needs.

Further consultation on the following issues is necessary before the SAO and facility placement committee structure is implemented:

- the role which local health units are to serve in this system; and,
- how the appeal process will work so service consumers and their families know what they may do if they do not approve of the facility placement committee's decision. The province should provide details on how long the appeal process would take and whether the appeal would be made to an elected body.

6 PROGRAM

6.1 AMO's General Concerns

Strategies for Change suggests a reformed long-term care program which would address the long-term care needs of the elderly and physically disabled adults. The program is to have six components: the service access organization and its facility placement committee, in-home service, community support service, specialized service, informal support, and long-term care facilities.

AMO has addressed its concerns with the service access organization and the facility placement committee in the previous section. This section comments on the program as a whole as well as the remaining components.

AMO has two major concerns with the long-term care program proposed in *Strategies for Change*. One is the exclusion of rest and retirement homes from the continuum of long-term care services, and the second is the inadequate treatment of the needs of the physically disabled.

Rest and Retirement Homes

Rest and retirement homes currently provide residence to an estimated 30,000 to 50,000 Ontarians.[11] In 1989, the Advisory Committee on Rest Homes submitted its report *Rest and Retirement: A Report on the Regulation of Residential Care Facilities* to the then Minister of Senior Citizen's Affairs, Mavis Wilson. The report was the result of almost two years of deliberations initiated by the report, *A New Agenda: Health and Social Services Strategies for Ontario's Seniors*. *A New Agenda* stated that the government should explore all appropriate options to ascertain the most effective means of addressing the rest homes issue and take the necessary steps to ensure that rest homes are subject to appropriate regulation.

Since the submission of *Rest and Retirement* in 1989, no official response has been received from the provincial government. While the *Report of the PMSSR* recommends that municipalities should be given authority to regulate, license and inspect rest homes if they choose to do so, the Association suggests that this should be considered in the context of long-term care reform.

However, *Strategies for Change* excludes rest and retirement homes from the long-term care services system. But, comprehensive reform of long-term care services addresses the need to provide a *continuum of care* from the individual's home to the different institutions. Rest and retirement homes are an important component of this continuum and are a necessary link in the long-term care system. As stated in *Rest and Retirement*, "the issue of rest homes must be viewed within the larger context of the continuum of care and services for Ontarians."[12]

> **RECOMMENDATION #5 :**
>
> The province should include rest and retirement homes as a part of the continuum of care in the reform of the long-term care system.

The Needs of the Physically Disabled

Strategies for Change does not adequately address the needs of the physically disabled. The report states at the beginning that the new long-term system will address the needs of the physically disabled as well as the elderly. But then the document appears to turn its attention to the elderly, and the needs of the physically disabled are not equally addressed throughout.

AMO believes there should be a major consultation with those representing the physically disabled adults who are expected to use this system. This consultation could be done both provincially and locally, and it could determine whether this new system is adequate for the needs it is supposed to serve.

RECOMMENDATION #6 :

The province should conduct a major consultation with those representing the physically disabled adults who are expected to use this system. This consultation should be done both provincially and locally, and it should determine whether this new system is adequate for the physically disabled adults it is supposed to serve. The program should not be implemented for the physically disabled until the province has addressed their concerns.

6.2 In-Home Services

In-Home Services are formal personnel support and professional care services - both medical and personal care - which are provided in people's home to allow them to live in their own homes and community. They also help to facilitate early discharge from hospitals.

The services include support for personal activities and professional health services, teaching and counselling, and availability is based in need. In-home services currently include such programs as Home Care, Integrated Homemaker Program, Outreach Attendant Care, Homemakers and Nurses Services, and the Home Support Program.

Strategy 2 of *Strategies for Change* notes that all current programs in this area are to be integrated and consolidated into one care and support service program. The aim is to provide a more co-ordinated system with a better range of services as an alternative to institutions. The co-ordinated program would have consistent eligibility criteria so service is provided based on need.

Strategies for Change states that a range and volume of in-home services is necessary in order to provide alternatives to institutional care. It is indicated that these services should meet both short and long-term service needs.

In order to fully evaluate this proposal further information is required on the following:

- A better definition of what is meant by in-home services;
- Whether people in rest and retirement homes may qualify for in-home services. *Strategies for Change* states these services are only available for those living at home;
- How will a wider range and volume of in-home services be developed to make these a viable alternative to institutional care for all the individuals soon expected to need these services?
- What are the costs and benefits of a wider range and volume of in-home services?
- What is the plan for implementing this unified program and how will it be phased-in?

RECOMMENDATION #7 :

A detailed strategy and cost-benefit analysis should be provided for developing a wider range and volume of in-home services so that these will be a viable alternative to institutional care. An implementation and phasing plan should be developed for this unified program.

6.3 Community Support Services

Community Support Services provide community support to individuals to allow them to stay in their homes. The services, often provided by volunteers, complement formal in-home services and the informal assistance provided by family and friends. The kinds of services available include: meal services, escorted transportation, home maintenance services, non-specialized day programs, health promotion, respite care, and social and security checks.

These programs have developed as separate entities with different policies, funding, and eligibility criteria. There are no provincial guidelines, so the availability of service is uneven, there is much duplication, the administration is complex, and the field is very confusing for people who want to access the services.

Strategy 3 of *Strategies for Change* states that an overall policy framework will be developed to give coherence to community planning, but that the community should not be unduly constrained. It also adds that a new partnership between community support service providers and government is required in order to develop this critical service. The document states that the community as a whole should plan community support services.

AMO requests that more information on the plan for developing a more co-ordinated community service system needs to be provided in order to evaluate this strategy.

6.4 Funding of In-Home and Community Support Services

Currently, there exists a vast array of in-home and community support services. Most jurisdictions with an integrated or single in-home service program control expenditures by establishing clear eligibility rules and setting limitations on the types of service or total resources that may be provided to an individual.

Community services are funded through contractual arrangements with the local Home Care office, Ministry of Community and Social Services area office, or municipality. Community service expenditures now are determined by the size of the total provincial allocation, the negotiated budget ceilings for community support services, the Home Care Program regulations and guidelines, and the case management function.

Strategy 4 of *Strategies for Change* states that the province has started working on a comprehensive funding program for in-home and community support services. This system is supposed to allow some flexibility within the allocation of in-home and community support service funds.

This new funding system is to have a single local budget which addresses differences in funding across the province and reflects different levels of need for service. *Strategies for Change* states that the new plan would use key indicators and community profiles to determine the level of need for community service. Work has just begun on this system, and it is proposed that this method be also used to adjust funding levels over time.

Strategies for Change states that local offices of the province's new community support services division will

work with local planning groups to determine which programs and services are most needed in order to allocate resources. Under this new system, local management staff is to plan with community groups and monitor service priorities in the area.

Further information and discussion is required to clarify the following:

- the role municipalities would have in funding in-home community support services;
- what are the best and most reliable indicators for determining the level of need for community support and in-home services? AMO suggests that these should not be based on population and that there should be a number of indicators incorporated in the determination of the local budget for each community;
- whether the province plans to bring all the different funding formulas used in community services into one criterion; there currently are many different systems and fees; and,
- who would administer the funding of in-home services?

6.5 Informal Caregivers' Support

Informal caregivers' support is the help provided to the elderly and physically disabled by families, friends, volunteers and others, such as neighbours. This groups provides 80 to 90 per cent of help required for daily activities of the elderly and physically disabled. Currently, there are counselling peer support and respite care services, such as adult day programs which involve elderly in activities during part of the day to provide relief to caregivers. There are also some respite co-operatives and host families, information services, support groups and self-help groups.

Strategies for Change recognizes informal caregivers are an important link in the long-term care system because they provide services which help people stay in their homes and communities. *Strategies for Change* proposes that support for this group should be enhanced and integrated as part of the overall system.

The report also states that caregivers may need support, such as information about chronic conditions, self-help groups and respite services. Expansion of respite services to provide caregivers with relief is proposed, and it is noted that support services should be available beyond the current program hours, particularly in the evenings and at night. *Strategies for Change* also states that policy planning is needed to enhance support services offered by community agencies, and discussions should be undertaken to ensure long-term care facilities can provide emergency respite care and pre-planned arrangements when caregivers cannot care for people in their own homes.

In the reformed long-term care system, the service access organization (SAO) is supposed to help caregivers by providing them with information about local services and programs, arranging assessments, making referrals to community support services, providing a single access point to in-home and long-term care facility services, and providing service co-ordination. In *Strategies for Change*, it is stated that in-home program personnel would also provide informal caregivers with service information, training in some procedures, counselling and respite care.

AMO applauds the province for recognizing this as an important area. But AMO suggests that the proposal has not gone far enough in explaining how the caregiver support services can be enhanced. In particular, AMO suggests the following three considerations:

1) More information should be provided on strategies to support this group.

   This is a critical area because voluntary caregivers provide 80 to 90 per cent of service now. If this group decided to reduce its service even by five per cent it would have a major impact on all other components of the long-term care system. The province now has to handle 20 per cent of the burden and that currently costs $2 billion. A five per cent reduction of caregiver service by the volunteer sector could cost the province another $.5 billion.

RECOMMENDATION #8 :

The province should provide more information on strategies to support informal caregivers.

2) *Strategies for Change* indicates interest in expanding the respite and day care programs which support informal caregivers. However other options should be examined, such as better training for informal caregivers, elder-sitting, support for self-help programs, and other aspects of a full range of weekend and evening in-home support which could be accessible on a spontaneous and informal basis.

RECOMMENDATION #9 :

The province should examine a full range of support services for informal caregivers. It should consider such options as better training for informal caregivers, elder-sitting, support for self-help programs, and other aspects of a full range of weekend and evening in-home support which could be accessible on a spontaneous and informal basis.

3) The province should consider ways of providing financial incentives for caregivers in the long-term care system.

RECOMMENDATION #10 :

The province should consider ways of providing financial incentives for caregivers in the long-term care system.

6.6 Long-Term Care Facilities

Long-term care facilities provide treatment, care and support for people with needs which cannot be met in their homes. These facilities include nursing homes, homes for the aged, and chronic care services. These facilities have been operating under different policies and legislation, and as opportunities for community living have expanded, the facilities have been providing care for individuals with more complex needs.

Access to facilities may presently be aided by a placement coordination service or depend on referral by family members and the family doctor. Some programs have also become outdated, which has contributed to problems in finding placement for those who require certain

kinds of services. *Deciding The Future of Our Health Care*, a discussion paper released by the Ontario Ministry of Health in April 1989, said, for instance, that the Ministry of Health was examining the use of institutional chronic care.

Strategy 7 of *Strategies for Change* states that the trend of long-term care facilities to increasingly serve people with heavy and complex care needs is likely to continue. Therefore, the goal is to co-ordinate the facilities' planning, policy and funding so that these would operate more efficiently and the existing bed supply would be used in the most effective way possible.

Strategy 7 is proposed to develop coordinated policies to enable these facilities' resources to be best used in serving this changing population. The funding components of this strategy were discussed in this paper's funding section. The program components of this strategy include:

a) The service access organization will oversee access to long-term care facilities, so only those who can not stay at home or in their communities will be admitted to facilities. Those who are admitted would only be sent to the most appropriate space. The facility placement committee would review applications to ensure this occurred.

b) The province will establish consistent accountability standards for service providers and the resources used in nursing homes and homes for the aged. Responsibility for the system will be placed within a unified management structure to ensure a single standard of service and single, coordinated approach to accountability for nursing homes and homes for the aged. The province will retain authority to allocate and distribute beds, approve homes, set standards, and monitor compliance.

c) Program standards for nursing homes and homes for the aged will be updated to ensure that these are tied to the funding/care levels. It is noted that the system also needs new programs such as respite care, convalescent, and short-stay programs.

d) The role of chronic units and hospitals in relation to long-term and acute care services will be reviewed. In the next phase of reform, a study of the current role and planning for the future role of chronic care will be conducted. This is deemed necessary before chronic care funding reform can be considered.

AMO suggests one important issue related to long-term care facilities requires further consideration. *Strategies for Change* infers a "no-growth" in beds policy for long-term care facilities. It is likely that a better developed system of in-home and community support services will reduce the rate of increase in demand for facility beds. However, in some cases, these services will just postpone the admission of individuals who, upon becoming very old and frail, will eventually need insitutional care. Also, the growth in the total elderly population and especially frail elderly is expected to continue. Therefore, it is unrealistic to assume that community support and in-home services will result in a zero increase in demand for institutional care.

6.7 Specialized Services

Specialized services are special services for people who have very complex, severe or unique needs. They include professional assessment, diagnosis, treatment, consultation, rehabilitation, and education. These services include Regional Geriatric Programs, day hospital programs, specialized day programs, Alzheimer's Community Program, and interpreter and intervenor programs for those with sensory impairments.

Ontario has been moving toward developing these special professional treatment and consultative services for the long-term care and support service system. But these services are presently not available in all areas of the province.

Strategies for Change does not provide many details about the future of specialized services in the long-term care service system. It states that these services would provide:

- a bridge between acute care hospital services and the community;
- a way to restore people's functional abilities and allow them to remain at home;
- expertise upon which other community and facility services could call for assistance; and,
- a way to provide special information to people, their families, and service-providers.

Strategies for Change notes the responsibilities of, and working relationships among, these key service components must be developed to enhance consumer services and staff skills. It also states that these areas must be examined in more detail. However, no details on funding for these services is provided. Presently, many of these services charge user-fees, and the province funds 100 per cent of the remaining cost.

Further information is required on how these services are to be funded; and, how specialized services are to be integrated into the continuum of long-term care services.

It is important to note that many of the specialized services such as geriatric assessment are useful in the assessment function of the facility placement committees; *Strategies for Change* should include an evaluation of what programs should be included as "basic" specialized services necessary for providing the required assessment functions for the SAO. In addition, it should address how these basic services could be made more readily available on a province-wide basis.

RECOMMENDATION #11 :

The province should review specialized programs to determine how these are to be funded; how they are to be integrated into the continuum of long-term care services; and what programs should be included as basic specialized services necessary for providing the required assessment functions of the SAO and how these can be made more readily available across the province.

6.8 Human Resources

Strategies for Change notes that there will be more demand for personnel and they will have to be trained and educated. It states that the system will have to look at new ways to recruit and retain people, the role of registered nurses in the long-term care system, and the need for other professionals to do assessment, planning, supervision, and provision of specialized care. More staff would also be needed in facilities and facility staff would have to have more consulting services to help them with complex care.

Before *Strategies for Change* was released, concern already existed about the payment to, and availability of, visiting homemakers. In recent years, their wages have increased from $4.50 to $8.30 per hour. In November 1989, on the recommendation of the Interministerial Committee on Visiting Homemaker Services, the province also announced a $28.9 million compensation improvement package for visiting homemakers. The money was part of an $88.8 million allocation the Minister of Community and Social Services previously announced to improve wages for workers in community agencies.[13] In his April 25, 1990 statement to the Ontario legislature, the then Minister of Community and Social Services also announced that the province would dedicate $52 million to the long-term care reform in the current fiscal year. Of that, $10.9 million would be used to improve wages and benefits paid to homemakers.

Strategies for Change notes that wages, benefits, training, supervision and agency operations must be further addressed.

AMO favours the concept of better pay for homemaking staff, since their availability is critical to this new system. However, AMO would like the province to provide more information on:

- what the cost implications will be for increasing homemakers' wages and meeting the province's other concerns in this area;
- what the funding implications of these will be for municipalities; and,
- the classification system for care. A proper balance must be achieved so there are enough classifications to avoid rigidity in the system and discourage turnover. But, there should not be so many classifications that care becomes too specialized and consumers have too many people servicing them in their homes.

AMO would also suggest that more attention should be given to encouraging people to study elder-care in high school and community courses. The provincial ministries involved in this reform should work with the provincial departments which can oversee such promotion.

6.9 Areas *Strategies for Change* Does Not Address

Strategies for Change discusses in-home and community support services and long-term care facilities, but it does not address options within the full continuum of care located between in-home care and long-term care facilities. For example, it excludes rest and retirement homes and other alternative forms of housing such as supportive housing arrangements, granny flats, home-sharing, etc.

Strategies for Change does not discuss individual health counselling, rehabilitative services, palliative care, or in-home hospice services. *Strategies for Change* also does not adequately address health services. In particular, it has excluded information on:

- the relationship between the health promotion - which includes diet, teaching, and help with medication - which public health units do, and the heavy care components already discussed in the document;
- chronic psychiatric care; and,
- community-based health care - such as outreach clinics -which is provided by physicians and hospital.

7 CONCLUSION

AMO's response to *Strategies for Change* illustrates that there are many questions and outstanding issues that must be addressed prior to the implementation of a successful reform of the long-term care system. The Association has focused its comments on the two main components of the proposed reform: the reform of long-term care services and the establishment of an integrated health and social services management structure.

The Association has argued that its contribution is both necessary and important to the success of both components of long-term care reform. Municipalities want to be partners with the provincial government in meeting the important objectives of long-term care reform. They have much to offer in experience and knowledge towards improving the services to the elderly and physically disabled living in their communities and should be consulted as a key government partner in this reform. The Association of Municipalities of Ontario presents this response to the new provincial government as a first step towards beginning dialogue and consultation on this most important issue.

AMO has recommended that the proposal in *Strategies for Change* to transfer responsibility for the management and planning of the long-term care system to a local authority be examined in the context of the *Report of the Provincial-Municipal Social Services Review*. In addition, AMO proposes that a consultation process should be established to address the program issues related to the reform of long-term care services that the Association has raised in this response to *Strategies for Change*. The Association would like to work with the provincial government to determine the best format for this consultation.

8 SUMMARY OF RECOMMENDATIONS

RECOMMENDATION 1 The province should undertake a study to determine the projected costs of long-term care reform and provide the information and research data which served as a basis for it's long term care policy recommendations.

RECOMMENDATION 2 The province and the Association of Municipalities of Ontario, through the PMSSR consultation process, should resolve the funding arrangements for the long-term care system.

RECOMMENDATION 3 The Association of Municipalities of Ontario should be consulted on the details of the user pay system. If municipalities are involved in cost-sharing long-term care services, then revenue from user-pay fees introduced in the long-term care system should help to offset municipal as well as provincial costs for this system.

RECOMMENDATION 4 If municipalities continue to have significant responsibilities in this area then municipalities should be offered the first opportunity to sponsor a service access organization in their communities. If they chose not to accept that opportunity, they then should be partners in determining how the SAO is to be established in their communities.

RECOMMENDATION 5 The province should include rest and retirement homes as a part of the continuum of care in the reform of the long-term care system.

RECOMMENDATION 6 The province should conduct a major consultation with those representing the physically disabled adults who are expected to use this system. This consultation should be done both provincially and locally, and it should determine whether this new system is adequate for the physically disabled adults it is supposed to serve. The program should not be implemented for the physically disabled until the province has addressed their concerns.

RECOMMENDATION 7 A detailed strategy and cost-benefit analysis should be provided for developing a wider range and volume of in-home services so that these will be a viable alternative to institutional care. An implementation and phasing plan should be developed for this unified program.

RECOMMENDATION 8 The province should provide more information on strategies to support informal caregivers.

RECOMMENDATION 9 The province should examine a full range of support services for informal caregivers. It should consider such options as better training for informal caregivers, elder-sitting, support for self-help programs, and other aspects of a full range of weekend and evening in-home support which could be accessible on a spontaneous and informal basis.

RECOMMENDATION 10 The province should consider ways of providing financial incentives for caregivers in the long-term care system.

RECOMMENDATION 11 The province should review specialized programs to determine how these are to be funded; how they are to be integrated into the continuum of long-term care services; and what programs should be included as basic specialized services necessary for providing the required assessment functions of the SAO and how these can be made more readily available across the province.

9 APPENDIX A

9.1 Definitions

Community

The term community has often been used to describe a geographically limited area. In addition to physical boundaries, the community can be defined by political labels that ascribe a status such as town, city or village to the geographic area. The word community can also be applied to groups of people who share particular traits, interests, concerns or beliefs. In this regard, we refer to communities of interest or communities of need.

In this paper "community" will be defined very broadly. For our purposes what a community is will depend on the context. The agreed upon or artificial boundaries of a community may be ideological, political or geographic. However, for the purposes of making recommendations concerning provincial-municipal roles and cost sharing responsibilities, we are using a geographical-political (i.e. governmental) concept of community."

Community Support Services

These services provide community support to individuals to allow them to stay in their homes. The services, often provided by volunteers, complement formal in-home services and the informal assistance provided by family and friends. The kinds of services available include: meal services, escorted transportation, home maintenance services, non-specialized day programs, health promotion, respite care, and social and security checks.

Devolution

This is the transfer of authority and accountability for selected functions from the provincial government to a local or community-based body.

In-Home Services

These are formal personnel support and professional care services - both medical and personal care - which are provided in people's homes to allow them to live in their own homes and communities. The services help individuals stay in their homes. They also facilitate early discharge from the hospital.

Informal Caregivers' Support

This is help provided by families, friends, volunteers and others, such as neighbours. This groups provides 80 to 90 per cent of help required for daily activities by the elderly and physically disabled.

Long-Term Care

Long-term care refers to a range of community, personal support, and health care services required on a periodic or ongoing basis by individuals, who, because of physical disability or aging, need assistance to function as independently as possible.

Long-Term Care Facilities

These provide treatment, care and support for people who have needs which cannot be met in their homes. The facilities include nursing homes, homes for the aged, and chronic care services.

Planning

As with any process aimed at the achievement of a goal - in this case, the creation of an effective social service system - the planning component can be broken down into various functions:

- Needs identification - assessment of local social service requirements.
- Priority setting - to realistically deal with limited resources for ever-increasing service requirements.
- Service planning - as a result of above; focusing on services necessary for the specific community.
- Facilitation of community development - by involving all the key players and stakeholders in a community's social service system.
- Implementation planning - taking into account other areas of human service planning in communities, e.g. health, education, housing, recreation, and land-use planning.
- Evaluation - a process to be established by which plans and results are regularly and periodically examined.[15]

Service Delivery

Service delivery refers to day-to-day provision of specific services to clients. Delivery may be undertaken directly, by

an organization's own staff, or indirectly, by using contracted services. The delivery agent is accountable for the effectiveness and efficiency of the service to the authority in charge of service management. The deliverer must carry out the requirements for the service established by the service manager and is accountable to the manager for funds spent.[16]

Service Management

Service management includes decision making authority for the quality and quantity of the service within the context of available resources and in accordance with provincial legislative and strategic policy positions. It includes responsibility for:

- setting goals, objectives, and priorities for the service
- developing local policy and program design
- determining the means by which a service is delivered to clients
- planning for operations and resources, including setting priorities and making allocations
- the establishment, control, and monitoring of operating standards for the service, within provincial strategic directions
- ensuring efficient and effective service delivery

There is an expectation that the party fulfilling the service management role will have sufficient resources to carry out these responsibilities, within the context of fiscal realities.[17]

10 ENDNOTES

1. Sources: Ministry of Community and Social Services, *Fact Sheet* (Toronto: MCSS, June 7, 1989); *Backgrounder* (Toronto: MCSS, December 6, 1989).

2. Ibid.

3. Ontario, Ministry of Community and Social Services and Ministry of Health, *Strategies for Change: Comprehensive Reform of Ontario's Long-Term Care Services* (Toronto: The Ministries, May 1990), p. 66.

4. Premier's Council on Health Strategy Integration and Coordination Committee, *Discussion Paper for Devolved Models of Health and Social Services* (Toronto: Peat Marwick Stevenson & Kellogg, June 1990).

5. Ontario, Provincial-Municipal Social Services Review Committee, *Report of the Provincial-Municipal Social Services Review* (Toronto: Ministry of Community and Social Services, Association of Municipalities of Ontario, Ontario Municipal Social Services Association, April 1990), pp. 176-177.

6. Ontario, Ministry of Health, *Deciding the Future of Our Health Care* (Toronto: Ministry of Health, April 1989), p.1.

7. Association of Municipalities of Ontario, *New Dimensions: The Report of the AMO Conditional Grants Review* (Toronto: AMO, 1990), p. 43.

8. Ibid., p. 44.

9. Ontario, Ministry of Community and Social Services and Ministry of Health, *Strategies for Change*, p. 51.

10. Association of Municipalities of Ontario, *New Dimensions*, p. 64.

11. Various estimates have been produced by different departments or organizations: for example, the Ontario Association of Non-Profit Homes and Services for Seniors estimate is 40,000; the Advisory Committee on Rest Homes in their report *Rest and Retirement: A Report on the Regulation of Residential Care Facilities* estimate is 30,000; and the Ontario Long-Term Residential Care Association estimate is 50,000.

12. Advisory Committee on Rest Homes, *Rest and Retirement: A Report on the Regulation of Residential Care Facilities* (Toronto: Minister for Senior Citizens' Affairs, April 1989).

13. Source: February 14, 1990 letter from then Minister of Community and Social Services, the Honourable Charles Beer, to AMO regarding AMO's 1989 conference resolutions.

14. From: *Report of the PMSSR Community Services Task Group* (Toronto: MCSS, January 1988).

15. Based on: Ontario Municipal Social Services Association, *A New Balance, A New Beginning* (Toronto: OMSSA, Sept 1988) and the *Report of the Provincial-Municipal Social Services Review*.

16. Ontario, Provincial-Municipal Social Services Review Committee, *Report of the Provincial-Municipal Social Services Review*.

17. Ibid.

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